PRINTED: 12/02/2015 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6012678		B. WING		C 11/12/2015	
NAME OF	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				11/12/2015	
PRESEN	ICE VILLA FRANCISC	AN 210 NORT		FIELD AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE	
S9999	S9999 Final Observations		S9999			
	Statement of Licensure Violations		mendalika ara arangakan			
	300.610a) 300.1210b) 300.1210d)2)3) 300.1210d)6) 300.3240a) Section 300.610 Re a) The facility shall if procedures governing facility. The written pure formulated by a few committee consisting administrator, the administrator, the administrator, the administrator, the administrator, the administrator administrator, the administrator and increase and other policies shall comply. The written policies the facility and shall by this committee, do and dated minutes of the facility shall process and personal control of the resident's comply and services to attain practicable physical, well-being of the resident resident to meet the care needs of the resident to meet the care ne	sident Care Policies have written policies and hig all services provided by the policies and procedures shall Resident Care Policy hig of at least the dvisory physician or the mmittee, and representatives his services in the facility. The revith the Act and this Part. Shall be followed in operating be reviewed at least annually ocumented by written, signed of the meeting. Heneral Requirements for hall Care Trovide the necessary care hall or maintain the highest mental, and psychological hident, in accordance with horehensive resident care horoperly supervised nursing hare shall be provided to each hototal nursing and personal hident. Heneral Requirements for		Attachment of Licensure		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/02/2015 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C IL6012678 B. WING 11/12/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH SPRINGFIELD AVENUE PRESENCE VILLA FRANCISCAN JOLIET, IL 60435 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

failed to assess, monitor, protect and document Illinois Department of Public Health

These Regulations were not met as evidenced

Based interview and record review the facility

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	STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	74101 234	IDENTIFICATION NUMBER: A. BUILDING:					COMPLETED	
L			IL6012678	B. WING			C 11/12/2015	
	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CIT	Y, STATE, ZIP CODE			12/2015
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	S9999	Continued From page	ge 2	S9999			*************************	
	I to correct The Agoob T side In accordance	findings for a Implar This resulted in R1 k bruising, swelling an stop bleeding from b of the device. This applied to one reviewed for residentransfers. The findings include: R1 was admitted to the admission face some transfers. The findings include: R1 was admitted to the admission face some transfers. The current Physician had diagnoses of My Gout, Heart Failure and R1's admission assets and the side of the chest. The port was accessed and the side of the chest. The port was accessed and the side of the chest that the port was accessed and the chest that the chest that the port was accessed and the chest that the port was accessed to the port was accessed to the port was accessed to	nted Vascular Access Device. Deing hospitalized with d pain. R1 had surgery to blood vessels torn at the site esident (R1) out of three t injury, neglect and the facility November 11, on September 2, 2015 per heet. In order sheet showed R1 elodysplastic Syndrome, and Urinary tract infection. Issment dated September 2, I an implanted port on the The assessment showed d and dressing changed on the nursing note dated howed R1 had a port on the hat was accessed and 1, 2015. The note lacks any or how it is accessed. The the access was working n. Sheet showed the Physician recin every 12 hours and fours (both antibiotics) to be Device. The Physician also and of the access device to	S9999				
	SI	te as ordered and to	change Intravenous tubing	V				
	as	s directed.						

Illinois Department of Public Health

ILEGOLATION NUMBER: A. BUILDING: C	STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILITIDE CONCEDITION				
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Summary statement of deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY Summary Statement of Deficiency Must be preceded by Full Regulatory or Lsc Identifying Information Deficiency Summary or Lsc Identifying Information Summary or Lsc Identifying Information Deficiency Deficiency Summary statement of Correction of Correction Should be CROSS-Referenced to the Appropriate Date Summary statement of Lsc Identifying Information Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary statement of Lsc Identifying Information Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Referenced to the Appropriate Date Summary or Lsc Identification Should be CROSS-Reference	I WANTE OF	LICANDER OR SUPPLIER	STREET AI	DDRESS, CIT	TY, STATE, ZIP CODE			
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R1's clinical record lacked consistent documentation of the site or its use. A nursing		and care of the acce	es doving the assessment	of the control of the			To a parameter	
documentation of the site or its use. A nursing		R1's clinical record I	lacked consistent	-				
The sale of the doc. Afful slight		documentation of the	e site or its use A pursing					
note dated September 3, 2015 at 6:37 AM, 10:58	!	note dated Septemb	per 3, 2015 at 6:37 AM 10:58					
AW snowed the access was used and remained	ì	AW snowed the access was used and remained						
intact. The next note describing the use of the		intact. The next note	e describing the use of the	The state of the s			1	
access was on September 9, 2015 at 1:15 AM		access was on Septi	ember 9, 2015 at 1:15 AM			1	İ	
of the device. The	of the device. There was no document showing the use of the device or an assessment of the site. The clinical record had no documentation to show a dressing/needle change was done. An incident report September 10, 2015 showed the facility received a call from R1's daughter while at an appointment with the Physician. R1's family told the facility R1 was being admitted to the hospital for a bruise on her left breast and chest. The report showed staff interviewed was able to use the port on September 9, 2015 during the 2:00 to 10:30 PM shift. R13 Registered					* 1980/Televier		
the use of the device. There was no document showing						AA Gran		
site. The clinical record had no do not do n								
Show a dressing/needle change was done								
An incident report September 10, 2015 showed								
the facility received a call from R1's daughter							1	
while at an appointment with the Physician R1's								
ramily told the facility R1 was being admitted to								
the nospital for a bruise on her left breast and					*Attention to the state of the			
cnest. The report showed staff interviewed was							1	
able to use the port on September 9, 2015 during								
Nurse reported the decide							l	
Nurse reported the device was used and there was a positive blood return.	\\\\\	rarse reported the de	evice was used and there					
On November 12, 2015 at 1:00 PM Z1 Medical	Ö	n November 12 201	15 at 1:00 DM 71 Madian					
Doctor stated R1 came to his office from the	D	octor stated R1 cam	le to his office from the					
nursing home with a large bruise and swelling on	nı	ursing home with a la	arge bruise and swelling on					
the left breast and chest. Z1 said blood vessels	[[]	e left breast and che	est. Z1 said blood vessels				1	
were torn and caused bleeding into the lower	W	ere torn and caused	bleeding into the lower				1	
chest and breast area. Z1 said the area was very	cr	nest and breast area	. Z1 said the area was very					
painful for R1.	με	initial for RT.	The state of the s					
Records from the community hospital showed	K6	tending notes to Ta	imunity hospital showed					
attending notes by Z2 an assessment that, "The	hla	ond was probable to	an assessment that, "The		Total Principles		1	
related to the manipulation of the name	blood was probably leaking from the trauma					1	l	
related to the manipulation of the access device	tha	at happened when D	21 was pulled. " The					
that happened when R1 was pulled. " The note	als	o describes R1 as h	naving severe to-de-				I	
to the area.	also describes R1 as having severe tenderness to the area						ĺ	
On November 10, 2015 at 2:36 PM E11 CNA			5 at 2:36 PM F11 CNA			Control of the Contro		

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6012678 B. WING 11/12/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 210 NORTH SPRINGFIELD AVENUE PRESENCE VILLA FRANCISCAN JOLIET, IL 60435 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 (Certified Nursing Assistant) said R1 did complain of pain to her arm. E11 pointed to the left side and said that was the side the arm was hurting. E11 cared for R1 on September 9, 2015 on the afternoon shift. On November 10, 2015 at 2:47 PM, E12 CNA said via telephone that care was provided to R1 on September 10, 2015 in the morning. "R1 had so much pain in her arm I could not finish dressing R1. I went and got E17 registered nurse." On November 12, 2015 at 11:45 PM E9 LPN (Licensed Practical Nurse) said on September 8 R1 complained of pain to the left arm. E9 gave R1 pain medication. E9 said there was no bruise at that time. E9 stated, "The resident told me the arm was hurting from the aides lifting her under the arms. ' There is no documentation of any assessments for these complaints made by R1 in R1's clinical Care plans for Intravenous Therapy in R1's clinical record dated September 2, 2015 showed the staff were to monitor the insertion access site and protect from injury. (B)

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